Rustic Pathways
GROUPS

MEDICAL & EMERGENCY INFORMATION FORM

This Medical & Emergency Information Form (hereafter "Form") must be completed honestly, accurately, and completely by an adult participant or the parent/guardian of a participant under the age of 22, with the participant's assistance. This information will be shared with Rustic Pathways, Australia (U.S.A.), Inc., (hereafter "Rustic Pathways") staff or contractors, medical professionals or others, as necessary, to address participant's health and medical issues. Otherwise, this information will remain confidential.

A review of the participant's submitted medical/health information is included in the Rustic Pathways enrollment process; information given does not necessarily exclude participation. Rustic Pathways needs accurate information to assist in understanding participant health issues. In addition, in the event of an injury or illness, this Form provides Rustic Pathways staff and emergency medical personnel with critical medical information. **Rustic Pathways strongly recommends all participants (and parent/guardian of minor participants) consult with their physician regarding the participant's intent to participate in a Rustic Pathways program in conjunction with completing this information.** This should include informing their physician regarding the Rustic Pathways specific trip location and activities as defined in the Program Itinerary, and the information sought and contained in this Form.

Part A: EMERGENCY CONTACT INFORMATION

Please ensure at least one emergency contact is a proficient English speaker.

Participant

First Name: _____ Middle Name: _____ Last Name: _____

Gender: _____ Date of Birth: _____ / ____ / ____ Cell Phone # While Traveling: _____
YYYY MM DD

Email Address: _____ State: _____ Country: _____

Primary Parent / Guardian / Emergency Contact

First Name: _____ Last Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ State: _____ Country: _____

Secondary Parent / Guardian / Emergency Contact

First Name: _____ Last Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ State: _____ Country: _____

Additional Emergency Contact

First Name: _____ Last Name: _____

Relationship to Participant _____ Cell Phone: _____

Email Address: _____ Home Phone: _____

Please note that in the event of an on-trip injury, Rustic Pathways staff may have to administer appropriate medication. Rustic Pathways will endeavor to notify minor participant's parent via the emergency contact information provided.

Part A: EMERGENCY CONTACT INFORMATION (Continued)

Primary Physician

First Name: _____ Last Name: _____

Office Phone: _____ Cell Phone: _____ Email: _____

Dentist / Orthodontist

First Name: _____ Last Name: _____

Office Phone: _____ Cell Phone: _____ Email: _____

Mental Health Professional

First Name: _____ Last Name: _____

Office Phone: _____ Cell Phone: _____ Email: _____

Other Medical Professional

First Name: _____ Last Name: _____

Office Phone: _____ Cell Phone: _____ Email: _____

Insurance Information

Is the participant covered by family medical / hospitalization insurance? ☐ Yes ☐ No

Name of Carrier/Provider:_____ Group / ID #: _____

Please carry a copy of your insurance and prescription cards while on your program

Part B: HEALTH HISTORY

The following information must be completed honestly and accurately by an adult participant, or the parent/guardian of a minor participant with the minor participant's assistance.

Allergies

Please list all known allergies (including but not limited to food (nuts, shellfish, and others), insects, plants, medications, etc.) and describe triggers, symptoms and severity of reaction (including anaphylaxis).

Allergy 1: _____ Reaction & Treatment: _____

Allergy 2: _____ Reaction & Treatment: _____

Allergy 3: _____ Reaction & Treatment: _____

Allergy 4: _____ Reaction & Treatment: _____

Is participant prescribed epinephrine or epi-pen for any allergy? ☐ Yes ☐ No

Sulfa Drugs: In many nations, Diamox, (an altitude sickness medicine) and other sulfa drugs are used.

Is participant allergic to sulfa drugs? ☐ Yes ☐ No

Current Medications

Please list all medications (prescription AND over the counter) that the participant will take (whether regularly or for episodic use) while on the trip. If participant is not taking medication, please indicate appropriately. Bring enough medication to last the entire trip. Keep prescription drugs in original packaging that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration. Please attach any additional that does not fit on this page.

*__Medication Warning and Policy__: Use of prescription and non-prescription drugs is a matter that Rustic Pathways takes very seriously. The abuse of prescription and over-the-counter medications is a growing problem among teens and we encourage all parents to openly discuss this trend and its dangers with their teenagers. Risks include, but are not limited to: participants bringing undisclosed drugs; swapping, selling or trading their medications with other program participants; and overdosing or other adverse reactions. All Participants will carry and administer their own medications and must understand how to responsibly use and administer their medications, per their physician's instructions. A participant's misuse of any medication will be grounds for dismissal from the program.

Is participant taking medication? ☐ Yes ☐ No

Medication 1: _____ Dosage: _____

Reason for Medication: _____ Frequency of Dosage: _____

Common Side Effect / Effects of a Missed Dose: _____

Medication 2: _____ Dosage: _____

Reason for Medication: _____ Frequency of Dosage: _____

Common Side Effect / Effects of a Missed Dose: _____

Medication 3: _____ Dosage: _____

Reason for Medication: _____ Frequency of Dosage: _____

Common Side Effect / Effects of a Missed Dose: _____

Are there any medications participant is currently taking that he/she will NOT be taking while on the program? ☐ Yes ☐ No

If yes, please explain: _____

Part B: HEALTH HISTORY (Continued)

Has the participant ever:

1. Had respiratory issues or Asthma?	☐ Yes	☐ No	2. Had diabetes? (Specify type below)	☐ Yes	☐ No
3. Been diagnosed with a heart murmur?	☐ Yes	☐ No	4. Had frequent headaches?	☐ Yes	☐ No
5. Had a head injury / concussion? (list date below)	☐ Yes	☐ No	6. Passed out during or after exercise?	☐ Yes	☐ No
7. Had chest pain during or after exercise?	☐ Yes	☐ No	8. Had joint problems / orthopedic device?	☐ Yes	☐ No
9. Worn glasses, contacts, or protective eyewear?	☐ Yes	☐ No	10. Had a chronic or recurring illness?	☐ Yes	☐ No
11. Been hospitalized?	☐ Yes	☐ No	12. Had surgery? (provide details below)	☐ Yes	☐ No
13. Had an eating disorder / engaged in self-abuse?	☐ Yes	☐ No	14. Had back problems?	☐ Yes	☐ No
15. Been addicted to or abused a substance?	☐ Yes	☐ No	16. Had skin problems?	☐ Yes	☐ No
17. Had mononucleosis in the past 12 months?	☐ Yes	☐ No	18. Had intestinal problems or disease?	☐ Yes	☐ No
19. Had problems with sleepwalking?	☐ Yes	☐ No	20. Had an abnormal menstrual history?	☐ Yes	☐ No
21. Had Frost Bite or Raynaud's Syndrome?	☐ Yes	☐ No	22. Seen a mental health professional?	☐ Yes	☐ No
23. Been diagnosed with Asperger's or Autism?	☐ Yes	☐ No	24. Had suicidal or destructive thoughts?	☐ Yes	☐ No
25. Had Chicken Pox?	☐ Yes	☐ No	26. Had German Measles?	☐ Yes	☐ No
27. Had Measles?	☐ Yes	☐ No	28. Had Mumps?	☐ Yes	☐ No
29. Had Hepatitis A?	☐ Yes	☐ No	30. Had Hepatitis B?	☐ Yes	☐ No
31. Had Hepatitis C?	☐ Yes	☐ No	32. Been diagnosed with HIV or AIDS?	☐ Yes	☐ No
33. Had a TB Mantoux test?	☐ Yes	☐ No	If yes, was the test:	☐ Positive /	☐ Negative
34. Had neurological problems such as seizures or epilepsy?				☐ Yes	☐ No
35. Had an illness, infectious disease, or injury in the past 3 months?				☐ Yes	☐ No
46. Had high blood pressure or other cardiovascular disease or condition?				☐ Yes	☐ No

If you answered "Yes" to any of the above questions, please provide details including nature of condition, treatments, dates, etc. (listing the item # you're referencing) here. Feel free to use additional pages if necessary.

_____

_____

_____

_____

_____

Part B: HEALTH HISTORY (Continued)

Has the participant ever:

37. Had bleeding, Deep Vein Thrombosis, or a blood disorder? ☐ Yes ☐ No

38. Had frequent ear infections or a hearing impairment? ☐ Yes ☐ No

39. Been Pregnant? (If you are currently pregnant, please provide details below) ☐ Yes ☐ No

40. Had adverse reactions to altitude, including acute altitude sickness or pulmonary/cerebral edema? ☐ Yes ☐ No

41. Had learning disabilities requiring special instruction? ☐ Yes ☐ No

If you answered "Yes" to any of the above questions, please provide details including nature of condition, treatments, dates, etc. (listing the item # you're referencing) here. Feel free to use additional pages if necessary.

_____

_____

_____

_____

_____

Swimming:
Please indicate participant's swimming ability in deep water (5 feet or more); consider comfort level and physical condition:
Note: Please let us know if you have concerns about participation in water-based activities, or if participant has a fear of the water.

☐ Advanced ☐ Competent ☐ Poor ☐ Non-Swimmer

Vaccinations:
Please provide dates (MM / YYYY) of participant's vaccinations and immunizations in the last 10 years. Participant should carry a copy of their vaccination history (such as a "yellow card") with them while traveling.

Measles, Mumps, & Rubella (MMR): _____ Hep A: _____ Hep B: _____

Meningococcal (Meningitis): _____ Tetanus: _____ Typhoid: _____

Japanese Encephalitis: _____ Rabies: _____ Yellow Fever: _____

Other: _____

Dietary Restrictions:

Does the participant have any medical dietary requirements? ☐ Yes ☐ No

If yes, please explain: _____

_____

Does the participant have any personal or religious dietary restrictions? ☐ Yes ☐ No

If yes, please explain: _____

_____

Part B: HEALTH HISTORY (Continued)

Additional Information:
Considering the nature of Rustic Pathways activities, does the participant have any condition/s or limitation/s (physical, mental, emotional), described in this Form or otherwise, which may affect the participant's well-being, the well-being of others, or affect the participant's ability to engage in program activities? ☐ Yes ☐ No

If yes, please explain. Include any adaptations or modifications you consider appropriate.

_____

_____

Is there any additional information about the participant that Rustic Pathways should be aware of?

_____

_____

Part C: ACKNOWLEDGEMENT, AGREEMENT, AND AUTHORIZATION

I (participant and parent/guardian of a participant under 22 years of age), agree as follows:

I certify that the information provided above (and in any supplemental information I submit) is true, complete, and accurate. Other than any limitation/s described in this Form or supplemental information, I agree participant can participate in all Rustic Pathways activities except those I specifically exclude in the Prohibited Activities Addendum. I understand the nature of Rustic Pathways activities, and acknowledge that I can contact Rustic Pathways should I have any questions about these activities and the associated physical, mental or emotional demands or other concerns. **I will contact Rustic Pathways via email if any medical history/condition changes before the start of (or during) the program, and understand that all participants share in the responsibility for their own well-being and the well-being of others on the program. I acknowledge that providing inaccurate medical information or falsifying medical information can create serious risks to participant or others, and/or result in participant's dismissal from the program. I understand that participant's final acceptance and participation in the program is contingent upon Rustic Pathways' receipt and review of all forms, including this Form as well as any additional submitted health information.** I understand that although Rustic Pathways will review this information and may allow participation, Rustic Pathways cannot anticipate or eliminate risks or complications posed by a participant's mental, physical (including fitness level), or emotional condition. I authorize Rustic Pathways employees or agents to secure medical attention and treatment deemed necessary or appropriate for the participant during the participant's trip, and if participant is under 22 years of age, Rustic Pathways may also share medical information with the participant's parent/guardian. I understand that emergency, medical, drug and/or health issues, response, assessment or treatment are included within the scope of – and expressly subject to the terms of – the Participant Enrollment Agreement.

I authorize my or my child's consulting medical care and/or mental health provider to release any information about my/my child's health or health care to Rustic Pathways, if needed.

I acknowledge that Rustic Pathways has recommended that the participant (and parent/guardian of a minor participant) consult with their physician (who is informed regarding Rustic Pathways program location and activities, including the contents of this Form), to determine if the Rustic Pathways program is appropriate for participant's participation. If I choose not to consult with said physician, I fully acknowledge, accept and assume the increased risks and all responsibility and liability for making that choice.

The participant and a parent/guardian of a participant under the age of 22 must sign below.

Signature of Participant_____ Date:_____

Signature of Parent/Guardian (if applicable)_____ Date:_____